# network

**NETWORK 19** 

OCTOBER 2007



What is the place of in-patient treatment for drug and alcohol problems?

An essential part of recovery, or an expensive and unnecessary intervention? James Bell examines the role of in-patient units in drug and alcohol treatment. While highlighting the important role in-patient treatment can play, he argues that this role is limited, and questions our current assessment procedures. Ed.

There are two distinct discourses about the role of in-patient treatment for addictive disorders, and they appear to take place in parallel universes.

On the one hand, there is the discourse of "recovery", in which in-patient treatment is seen as a potential turning point, the moment when a person adversely affected by alcohol or drugs makes the decision to renounce their destructive lifestyle, and to go "clean". From this perspective, no drug-dependent person seeking in-patient treatment should be denied the opportunity to pursue their personal recovery. This is the basis of claims that in-patient detoxification should be available to anyone who asks for it. Treatment services, on this model, are a setting of optimism, peer support, and professional assistance to the recovering addict. This is what consumers, parents, and many referrers want from treatment. Every professional working in the field has



experienced the joy of seeing personal transformation occur. A drug user enters treatment sick, surly, and negative, and emerges after some weeks well, drug-free, and with a positive attitude.

On the other hand, there is the discourse of evidence-based health care, and the requirement that health services must be both effective and efficient, making good use of taxpayer's investment by contributing to public health. This discourse paints a rather bleak view of in-patient treatment, which is not more effective than ambulatory treatment, and considerably more expensive. A recent NTA review of treatment of alcohol problems concluded that in-patient treatment is not more effective than outpatient treatment<sup>1</sup>, and for this reason, most services have moved towards ambulatory treatment. However, the authors note that ...continued overleaf

#### In this issue

Brian Whitehead describes how despite the improvements in treatment for HIV, the infection remains worryingly undiagnosed. He puts forward a persuasive argument that in order to improve diagnosis of HIV, the testing procedure should be normalised, in line with other health tests that hold serious consequences for the patient. Page 3

Jim Barnard gives an update on the **new clinical guidelines and NICE guidance. Page 3** 

Mick McKernan highlights the prevalence of Infective Endocarditis amongst IV drug users. He gives a thorough description of the symptoms and essential advice on how to identify this difficult to diagnose disease. Page 6

Pauline Bamgbala describes how the North East Lincolnshire **DIP** services offer more than just substitute prescribing to offending drug users by addressing their general health and social needs as well. **Page 7** 

Chris Ford discusses the difficult and often neglected area of the combined use of alcohol and opioids. Despite the fact that nearly a third of those in treatment for opiate dependence are heavy drinkers posing serious risk to their health, she suggests that services are poor at diagnosing and treating combined alcohol and opiate use. Page 8

Melissa Whitworth summarises the findings of her appraisal of local maternity service guidelines for substance misuse during pregnancy. She highlights the significant negative effects of substance misuse on maternal fetal and neonatal health, and finds that local guidelines, where they exist, could be better. Page 11

Kate Halliday provides a guide to the Children Act 2004, due to be implemented by the end of 2008. The Act aims to involve all health and social care agencies in the provision of early assessment and intervention for children in need, and emphasises the importance of preventative work with children and their families. Page 12

Dr Fixit James Bell replies to a question about in-patient drug detoxification. Page 13 and James Oliver gives advice on how to work problematic cannabis use. Page 14

Catch up with the latest news on the bulletin board. Page 16

We hope you enjoy this issue.

Editor



Don't forget to become a free member and receive regular clinical and policy updates - the newsletter can also be emailed to you - all for free www.smmgp.org.uk/membership

#### Editorial

The NICE guideline on opioid detoxification has challenged a number of traditionally held views regarding the best way to withdraw from opioids. James Bell gives an interesting view on in-patient treatment which may lead practitioners to question their current practice.

There has been a wealth of NICE documentation published over the past 12 months and with the addition of the new clinical guidelines we are excited to announce that we are publishing a **Special Edition of Network** in November. This will include key messages from the guidance, and give views from lead practitioners in the field on the impact the documents are likely to have on drug treatment in primary care. So don't miss it!

We are very pleased that our membership continues to grow, and we will be conducting another survey in the coming weeks asking how you are implementing the clinical guidelines, so look out for this and the results which will be published in Network 20.

We are busy planning for next year's RCGP conference in Brighton (24th and 25th April 2008) and are keen to get any papers, posters and other media from you- we are not just looking for research, we are also interested in patient leaflets, descriptions of service developments and posters advertising your service- the best entries will get a prize! For more details visit www.smmgp. org.uk

Enjoy this issue, Kate Halliday

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there is a clinical consensus that some people require in-patient treatment – either because of risk of adverse events, or because it enhances the likelihood of a good outcome. In relation to the treatment of opioid dependence, outcome studies suggest that brief episodes of treatment (less than 3 months) do not increase the likelihood of a person becoming long-term abstinent (and, indeed, increase the risk of death by overdose in the months following admission). In the face of such evidence, there appears to be at best a very limited place for in-patient treatment.

Can we reconcile these two discourses, and provide a real-world appraisal of the role of in-patient treatment? Admission can at times be life saving, and occasionally life changing, but mostly it is not. More often, in-patient detoxification programs can be useful to interrupt a period of escalating, high-risk drug or alcohol use, allowing people to regain, even if only temporarily, health and control. We can probably improve those outcomes by using in-patient care to foster engagement in long-term treatment. After leaving treatment, even those patients who do not engage in further treatment often sustain prolonged periods of reduced use or abstinence. However, in-patient detoxification is neither necessary nor sufficient for recovery; and recommending alternatives to in-patient treatment is not denying effective treatment.

There are problems with in-patient treatment beyond its modest, shortterm efficacy and considerable cost. Sometimes admission is a waste of time, in which patients seeking detoxification smuggle drugs into the unit, act out towards staff, disrupt therapeutic groups, form inappropriate relationships with other patients, and leave to resume their unchanged lifestyle. Such patients compromise the safety and effectiveness of in-patient units. Why do they seek admission? For patients with few social supports, an in-patient admission may represent a break not otherwise available to them. As one person in an in-patient unit commented when asked why people sought admission "Some people come here for a lie down."

Clinicians respond to this uncomfortable dilemma by trying to screen out people perceived as "unmotivated". Delays to entering treatment, and close questioning of patients about their plans

for ongoing care, are commonly used to test whether patients are "motivated". Such procedures are counterproductive. Patients soon learn what to say to gain admission. To the extent that barriers to admission select a particular clientele, people seeking respite or a break from routine are the people most likely to tolerate delays, while people who are sick and chaotic, and most at risk of harm, are least likely to negotiate the process.

If we can avoid the excesses of fuzzy optimism and burnt-out cynicism, there is a valuable, but limited, role for inpatient treatment. However, it will be a long struggle to persuade practitioners to move towards this style of treatment. Families and consumers have unrealistic expectations of "detox", which many professionals, with their own commitment to traditional practices, are tempted to encourage.

The "default option" for all people seeking treatment is ambulatory management. People at risk of harm and people at risk of major withdrawal, may need inpatient treatment. When they do, delays to admission are not appropriate. Rather than relying on patients requesting inpatient treatment, and then asking them to jump through hoops to demonstrate their readiness, we need to identify clear indications for in-patient treatment. Some people need in-patient treatment as a matter of safety (such as people at risk of major withdrawal, people exhausted and unwell after a binge, people at high risk of harm during periods of heavy drug use). Some people need containment (for example, people with a degree of paranoia or delirium after prolonged stimulant use), and some people (particularly, those who fail ambulatory treatment) may benefit from elective inpatient withdrawal in order to have a chance for their mental and physical state to improve.

In short, we need to move towards indications for admission being based upon health needs, rather than on patients' requests for admission. Treatment services should not insist on abstinence as the only option, even though patients may choose abstinence as their preferred goal.

**James Bell** Consultant in Addictions at SLAM (South London and Maudsley NHS Foundation Trust).

#### References

1 Raistrick D, Heather N, & Godfrey C (2006). Review of the effectiveness of treatment for alcohol problems. NTA, London

### Department of Health and NICE guidance Update



Jim Barnard gives an update on the new clinical guidelines and NICE guidance. Ed.

Since the last edition the NICE guidelines on psycho-social interventions and detoxification

have been published. The psychosocial guideline was reduced to just 3 key implementation priorities: Self Help, Brief Interventions and Contingency Management. Contingency management was the largest section and will be initiated into the NHS via demonstration sites. The detoxification guideline had 4 key implementation priorities which were: the need for good advice and information and informed consent; that methadone and buprenorphine should be the first line treatments; ultra rapid detox should not be undertaken and that the routine setting for detox should be in the community. Read them on the NICE web-site http://www. nice.org.uk/guidancesearch.aspx?o=G uidanceFinder&ss=substance+misuse The new clinical guidelines have also been published and are available on the NTA web-site www.nta.nhs.uk.

In order to inform readers in more detail of the content and implications of the new guidelines including the whole suite of NICE documentation (which also includes the guideline on vulnerable young people and technology appraisals on buprenorphine, methadone and naltrexone) SMMGP will be producing a **special edition of network** which will present the key messages and implications for primary care from all these documents, as well as comments and interpretation from leading practitioners. We hope you will find it useful. This will be published in November to coincide with the NTA's dissemination strategy.

#### **Jim Barnard**

SMMGP Policy Advisor

# Getting HIV testing into General Practice: Opportunistic opportunities for improving testing

Is the emphasis on pre and post-test "counselling" hindering diagnosis of HIV? Brian Whitehead describes how despite the improvements in treatment for HIV, the infection remains worryingly undiagnosed. He puts forward a persuasive argument that in order to improve diagnosis of HIV, the testing procedure should be normalised, in line with other health tests that hold serious consequences for the patient. Ed.

#### **Background**

The management of HIV has changed significantly since 1995 and the introduction of highly active antiretroviral therapy (HAART). HIV has now become an eminently manageable condition similar to other long term chronic conditions such as diabetes, asthma, chronic obstructive pulmonary disease etc that are extensively managed in general practice, if monitored and managed appropriately.

Since the uptake of HAART there has been a two-thirds reduction in deaths from AIDS. However in order to benefit from such treatment, it is necessary to be tested for HIV

According to the Health Protection Agency (HPA)¹ there are approximately 63,000 people infected with HIV in UK.

66 Almost a third of people with HIV in the UK remain undiagnosed.

Over half of drug users infected with the virus are unaware of their infection<sup>1</sup> ??

HIV is often diagnosed late, when people present with significant immune damage and morbidity. This is the main reason for continued mortality among people with HIV.

In the UK sex between men remains the highest risk behaviour for acquiring HIV infection with evidence that transmission is continuing at a substantial rate. In 2005, 70% of those diagnosed were people aged 15-39, and 73% of heterosexual cases were in people of African origin or who had acquired the disease there. The HPA also reports a continuing increase in HIV, and other blood borne viruses (BBVs) notably Hepatitis C in drug users, especially in London <sup>1</sup>.

In 2005 34% of newly diagnosed patients were diagnosed late with serious immunosuppression and 11% had progressed to AIDS.

66 A recent British HIV Association (BHIVA)
Mortality Audit 2 suggested that at least a quarter of the deaths reported in HIV positive individuals in the UK between 2004-5 may have been prevented if diagnosis had occurred earlier in HIV infection ??

It noted that HIV diagnosis came too late for effective treatment for 93 HIV positive individuals (accounting for 24% of all deaths and 35% of all deaths in that period). The number of deaths due to late diagnosis was considered to be a minimum figure since some of the 'all deaths' statistics were attributed to untreatable complications of HIV, which also involved conditions that could have been prevented by earlier treatment. Late diagnosed patients were more likely to be under 30 years old and to be of non-white ethnicity than patients dying in other scenarios. Causes of death due

...continued overleaf

to late diagnosis were most often classical AIDS defining conditions, including PCP pneumonia, TB, and other opportunistic infections.

In 16 cases the audit found that there may have been a delay in a doctor diagnosing HIV after the patient had presented with symptomatic illness. Deaths due to delay in these circumstances were more likely to occur in older white patients who had a perceived low risk of HIV. This is consistent with a report from the UK's HPA two years ago which found that GPs are not testing for HIV when individuals who think that they are at low risk present with symptoms of immuno-suppression.

Late presentations and late diagnosis both contribute to unnecessary early deaths and more complicated morbidity.

66 By offering HIV tests where clinically indicated general practitioners can therefore ensure that their patients are able to take advantage of appropriate life-prolonging treatment and will help to avoid the risk of onward transmission. ??

#### **What can General Practice do?**

General practice has an important and significant role to play in improving individual and public health. Its role for delivering on public health benefit has been evidenced e.g. cervical cytology and MMR immunisation programmes.

General practice sees 95% of the population in 3 years. In a recent BHIVA audit<sup>2</sup> 71 (41%) of a cohort of 170 patients with symptoms before diagnosis had attended their general practice. In another evaluation study, of a cohort of Africans presenting for HIV treatment at London treatment centres, 85% were registered with a GP, and 75% had seen their GP in the last 2 years before their diagnosis<sup>2</sup>. Chest complaints, flu-like symptoms and skin problems were the most commonly reported symptoms.

General Practice will see patients who may not be accessing any other services. It may see those who are at greatest risk, and it has the potential to provide pragmatic risk reduction interventions that are patient centred.

General practice potentially has a significant role in HIV management in providing a range of interventions from risk assessment and risk management (the essential work of general practice), testing and early diagnosis, monitoring of CD4 and viral load counts, general medical services, harm reduction interventions, support and access with and to specialist services, and most significantly the holistic management of chronic conditions. There is also a vital role in the care of those who choose not to attend a specialist clinic. Monitoring of CD4 counts to determine immune status and offering prophylaxis against PCP to those whose counts are below 200 can impact significantly on the health of patients.

As HIV has become a treatable condition there has been a major change in attitudes to testing. When talking to patients about HIV, practitioners can now be more confident that treatment can prolong life expectancy in infected individuals. Increasing awareness of signs and symptoms and risk factors for HIV and the benefits of HIV testing can result in earlier identification of people with HIV infection. GPs should think about discussing HIV testing with individuals who have risk factors for HIV or have diseases that are HIV related (TB, multi dermatotomal HZV, oral candida). Earlier diagnosis can improve their prognosis by allowing monitoring and treatment if required.

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#### $\rho$ 32 Guidance for the Prevention, Testing, Treatment & Management of Hepatitis C in Primary Care

- RCGP (1st Edition, 2007, Updated 20-06-07)

GPs should be considering HIV testing with common presenting problems such ad sebhorroeic dermatitis, and atypical psoriasis as part of the differential diagnosis <sup>3</sup>.

## Guidelines on HIV testing: What to look out for and WHEN TO TEST FOR HIV

HIV testing should be offered wherever knowledge of the individual's HIV status could improve or affect clinical outcome.

Doctors should think of HIV and strongly recommend HIV testing whenever there is:

Any unusual manifestation of bacterial, fungal or viral disease, i.e.:

- infection with tuberculosis
- suspected Pneumocystis carinii pneumonia
- suspected cerebral toxoplasmosis
- oral/oesophageal candidiasis
- hairy leucoplakia
- persistent genital ulceration

- presence of another blood-borne or sexually transmitted infection, e.g. syphilis, hepatitis B
- suspected primary infection with a seroconversion illness (e.g. flu-like illness, suspected glandular fever with negative EBV serology)
- unusual tumours, i.e. cerebral lymphoma, non-Hodgkin's lymphoma or Kaposi's sarcoma
- unexplained thrombocytopenia or lymphopenia
- unusual skin problems such as severe sebhorroeic dermatitis, atypical psoriasis or extensive molluscum; and, re-occurring herpes zoster or herpes zoster in a young person
- persistent generalised lymphadenopathy or unexplained lymphoedema
- neurological problems including peripheral neuropathy or focal signs due to a space-occupying intra-cerebral lesion
- unexplained weight loss or diarrhoea, night sweats, or pyrexia of unknown origin
- any other unexplained ill health or diagnostic problem.

In addition, for problems which require immunosupression, the exclusion of HIV should be considered prior to treatment. This list is not intended to be exhaustive and physicians are encouraged to use their clinical judgement.

At the conclusion of their audit BHIVA recommended that it was extremely important to communicate the impact of late diagnosis to non-HIV clinicians and in particular to primary care doctors working in general practice. It also recommended that both the Expert Advisory Group on AIDS and the Department of Health consider how to promote more routine HIV testing in generic health services and that earlier this year recommended that "opt out" testing should be offered to all patients in sexual health settings regardless of risk factors for infection.

Early presentation must be encouraged as treatment is far more effective before infection develops into full AIDS. There is also less time in which the person may, whilst ignorant of their infection status, transmit the infection to others.

appropriate to lower thresholds for HIV testing by reducing the emphasis on pre-test counselling, and "normalising" the testing procedure. HIV testing should now not be afforded any special status, and GPs should now undertake the test by using the same approach as used in any other test with serious implications. 99

The pre-test counselling process occurs to ensure that every patient is able to provide informed consent for the test being undertaken. But why does HIV testing afford specifically informed consent at all <sup>4</sup>? Ideally informed consent should be obtained for all medical investigations and interventions.

In practice blood testing for other life altering conditions (such as tumour markers for cancer) is routinely undertaken with little

discussion with the patient of the test's implications, much less an indepth counselling discussion about the patient's risks, the meaning of a positive/negative result how they would cope and what would happen if a positive result was found, all essential components of pre test counselling. The practice of counselling confers a stigma upon the disease which is detrimental to those affected by it. This stigma must dissuade an at risk patient from having a simple yet important test that could prolong their life. It is the doctor's duty to investigate patient's symptoms. If an HIV test is a rational and important investigation as part of that patient's diagnostic pathway, the test should be undertaken just as one would request an x-ray for suspected lung cancer, or a cea blood test for colon cancer. Discussions about the implications of any of these tests should be equally thorough <sup>4</sup>.

Testing rates are low in general practice but increasing ¹. There are concerns from patients and practitioners regarding confidentiality, legal and insurance issues, self perceptions of low risk and fear and denial by both parties ⁵. In some respects some GPs and other members of the primary care team and their staff are in a "timewarp" regarding issues of insurance and GP reports, and their knowledge is historically out of date. Many report having had no training on this issue. There is however clear guidance available from the BMA and the Association of British Insurers. Additionally there are excellent guidance proformas from the RCGP Sex Drugs and HIV Task Group for HIV testing, and also other blood borne viruses ⁶. It is evident that GPs, and general practice needs more training in this domain, and that must include all practitioners, and never forget the receptionists.

Times have changed. The benefits of early diagnosis are multiple. HIV testing should be normalised. GPs should undertake the test using the same routine approach as any other test with serious consequences <sup>4</sup>.

General practice can rise to this substantial health crisis and have an important individual and public health benefit. Think HIV, but on a personal plea, don't forget the other BBVs either, and particularly Hep C, and the future public health crisis that threatens with such significant under-diagnosing.

#### **Brian Whitehead**

Counsellor BBVs London

Member RCGP Sex Drugs and HIV Task Group.

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### Infective Endocarditis in IV Drug Users

Mick McKernan highlights the prevalence of Infective Endocarditis amongst IV drug users. He gives a thorough description of the symptoms and essential advice on how to identify this difficult to diagnose disease. Ed.

Infective Endocarditis is common in IV drug users.

In one study of injectors, the incidence has been reported as 7 cases /1000 person- years. It is higher amongst those with HIV infection, a history of previous infection and in women <sup>1</sup>. Co- existing cocaine use seems to particularly increase the risk<sup>2</sup>.

IV drug use accounts for 15-35% of all cases of endocarditis. Recurrence of disease in non-IV drug users is between 4-7%. In IV drug users, the recurrence rate can be as high as 40%.

The presentation of Infective Endocarditis in IV drug users is unusual in that it has a propensity to affect the right side of the heart <sup>3</sup>. The tricuspid valve is affected in 50% of cases, the aortic in 25% and the mitral valve in 20%. The prognosis is more favourable if the right side is involved. The presence of multiple lung abscesses in IV drug users should prompt a search for underlying IE. In IV drug users it also often presents with manifestations of metastatic infection.

In addition, S. aureus (70%) infection is more common in IV drug users followed by streptococci (8%)<sup>4</sup>. Infection by unusual organisms, such as Lactobacillus and Corynebacterium spp, also occurs with increased frequency in IV drug users. The overall mortality rate is about 10% <sup>5</sup>.

**Symptoms** at least initially are often vague and ill defined and may include

the following:

- Fatigue
- Weakness
- Fever often described as spiking
- Chills
- Night sweats (may be severe)
- Weight loss
- Muscle aches and pains
- Heart murmur
- Shortness of breath with activity
- Swelling of feet, legs, abdomen
- Blood in the urine
- Excessive sweating
- Red, painless skin spots on the palms and soles (Janeway lesions)
- Paleness
- Nail abnormalities (splinter hemorrhages under the nails)
- Joint pain
- Abnormal urine color
- Red, painful nodes (Osler's nodes) in the pads of the fingers and toes

Diagnosis of endocarditis is notoriously difficult. However amongst patients who do use illicit drugs and have a fever there is about a 10% to 15% prevelance in those presenting for medical attention. This estimate is not substantially changed by whether the doctor believes the patient has a trivial explanation for their fever <sup>6</sup>.

The diagnosis can be further aided by the detection clinically of a heart murmur suggesting involvement of a cardiac valve

#### **Key learning points**

New/ changed heart murmur + fever = infective endocarditis until proven otherwise.

Always consider infective endocarditis as a possible diagnosis in any IV user that becomes acutely unwell.

Where there is a degree of suspicion at least 2 sets of blood cultures should be undertaken<sup>7</sup>.

These will detect the majority of cases. It is important to note that the diagnosis of IE can be made in the presence of negative blood cultures. If the diagnosis is unclear, it is recommended to use The Duke criteria<sup>8</sup> to confirm the diagnosis of IE.

#### Major criteria

 Positive blood cultures: Isolation of typical micro organisms causing endocarditis from two separate blood cultures  Evidence of endocardial infection on echocardiography. The presence of a vegetation (i.e. mass of thrombus and bacteria which moves with blood flow/ cardiac movement) or abscess is a strong indication of intracardiac infection

#### Minor criteria

- 1. Presence of a predisposing factor: e.g. I.V. drug use
- 2. Fever: Over 38°C
- Presence of 'vasculitic' lesions:

   e.g. glomerulonephritis, Osler's nodes, Roth's spots, rheumatoid factor
- Vascular phenomenon: e.g. Major arterial emboli, Janeway's lesions, intracranial haemorrhage, conjunctival haemorrhages
- Microbiological evidence: positive blood culture but does not meet a major criterion as noted above or serological evidence of active infection with organism consistent with IE

The diagnosis of endocarditis is made by the presence of two major criteria

Or:

**one** major criteria and **three** minor criteria

Or:

five minor criteria

Treatment of endocarditis invariably involves hospitalisation for further evaluation and evaluation and commencement of antibiotic therapy.

**Dr M F McKernan.** GP Specialist Salford Drug Team

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# North East Lincolnshire Drug Intervention Programme

Pauline Bamgbala describes how the North East Lincolnshire DIP services offer more than just substitute prescribing to offending drug users by addressing their general health and social needs as well. She highlights the surprisingly poor health of this group, their lack of previous contact with primary care, and the importance of actively attempting to retain offending drug users in treatment.

North East Lincolnshire PCT and Drug Action Team have a long history of working with GPs who provide treatment and care for drug misusers.

A shared care scheme, supported by the specialist service, provides treatment and care for around 350 people not involved in the criminal justice system. A local GP also runs the prescribing service for the agency responsible for Drug Rehabilitation Requirement (DRR) and Drug Treatment and Testing Orders (DTTO). It was therefore a natural progression for us to look at how primary care could be involved in the Drug Intervention Programme (DIP).

A series of meetings took place with our shared care GPs, the PCT & DAT (who commission the DIP service) and it was agreed that GP sessions would be available 3 times a week. The GPs were keen to ensure that their role was not limited to 'signing' scripts and actively sought engagement with the clients. To facilitate this, it was agreed that drug counsellors would work alongside the GPs and that there would be input from a community outreach nurse practitioner (also funded by the DAT).

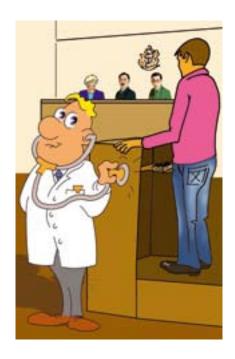
Whilst the GPs would take care of the prescribing and other associated medical needs, the importance of the wrap around services provided by the other DIP staff could not be overlooked. A multi agency staff, all housed in the same building, would work towards providing a holistic service which encompassed both health and social needs. With all this on offer, we thought the clients, first seen by the Arrest Referral Workers in the cells, would jump at the opportunity to engage – but was that wishful thinking on our part?

Our treatment service went live on the 2nd August 2004. It soon became apparent that the attitude of clients who actively seek to engage with treatment services in an attempt to address their addiction is very different to the clients who are, to all intents and purposes, coerced into treatment. Whilst acknowledging that their offending was problematic to themselves and the wider community, issues relating to chaotic drug use and obvious associated health problems had not previously been considered or identified as a high priority.

The GPs involved in the scheme were genuinely appalled at the poor general health of this client group. Although the majority of clients were registered with GPs, many of them had not sought help for a range of potentially serious health Interestingly enough, whilst it is acknowledged that there still exists a number of GPs unwilling to be actively involved in the treatment and care of drug misusers, the majority of clients had not sought any general medical services from the GPs they were registered with. Malnutrition, DVTs, mental health, BBVs and dental problems were and continue to be commonplace. All of these issues are compounded by wide ranging social issues.

Because the clients were having to attend the DIP team regularly (up to three times a week) and were frequently seen by the GPs for on going assessment, solid relationships were established that enabled the GPs and nurse to address many of the physical health needs of the clients.

Ensuring the clients remain engaged with treatment services after their 12-week programme at DIP comes to an end is an issue the GPs were keen to address. Referral pathways into all services were put in place and weekly meetings of all treatment providers ensures clients are transferred to an appropriate service – e.g. shared care (with the likelihood that the GP they have seen in DIP will take over their care), the community drug service (again provided by GPs), or the specialist service.



Clients who fail to attend appointments with new service providers are identified and DIP staff will actively seek them out, and accompany them to the new service until they are settled.

As commissioners of this service, we measure the success of our primary care involvement not just by the number of people who pass through the door and are titrated and stabilised before transfer to other services, but by the positive impact this initiative has had on the general health improvement of this client group. In addition, it is fair to say that the clients have also played a large part in the ongoing development and knowledge base of the GPs!

To the question would the clients want to engage? – I think this has to be an unequivocal yes. The relationship established between the GPs, the DIP staff and the clients has enabled the service to expand its original remit to incorporate fast track referrals to other elements of primary and secondary care and has given the clients more confidence to address their health issues in the knowledge that engagement with the DIP is so much more than a prescription for methadone and reducing offending behaviour.

#### **Pauline Bamgbala**

Head of Substance Misuse/Sexual Health Commissioning

North East Lincs PCT/DAT

# Alcohol and opioids — a difficult and neglected problem?

When providing substitute medication to opioid users don't forget alcohol

Chris Ford discusses the difficult and often neglected area of the combined use of alcohol and opioids. Despite the fact that nearly a third of those in treatment for opiate dependence are heavy drinkers posing serious risk to their health, she suggests that services are poor at diagnosing and treating combined alcohol and opiate use. She assesses current interventions for this group, and calls for more research into what works in this complex area. Ed.

#### The problem

There is increasing concern about the prevalence of harmful alcohol consumption in the drug treatment population<sup>1</sup>, in particular the role alcohol plays in overdoses<sup>2</sup>, which is known to be worse in people who inject drugs<sup>3</sup>. There is also concern about the effects of alcohol on those with hepatitis C<sup>4</sup>. The NTA state that alcohol is a major contributing factor to illness and death for clients of drug services<sup>3</sup>.

#### **Alcohol and opioids**

Most opioid users have substantially lower rates of alcohol consumption than the general population but heavy drinkers account for at least 30% of the treatment group and present significant difficulties. They show poorer outcomes including sexual risk taking, suicidality, overdose risks and exacerbation of HCV. Alcohol dependence is highly associated with polydrug dependence and bingeing (acute high intake) will induce methadone withdrawal symptoms.

#### What happens?

The combination of alcohol with opiates can cause: respiratory depression, hypotension, sedation, higher risk of overdose and a higher risk of toxicity as the metabolism is slowed.



The patients at high-risk of toxicity are problem or alcohol dependent drinkers, those with recent benzodiazepine use or use of other sedating drugs such as: antipsychotics and sedating antidepressants (particularly if a drug is started or increased within the last two months, or they are taking moderate or high doses). Older patients (>60 years) and those who have chest disease or liver disease are particularly at risk.

#### **Concurrent use of other drugs**

Concurrent use of alcohol, benzodiazepines and other sedating drugs substantially increases the risk of methadone overdose death. One study found evidence of polydrug use in 92% of methadone-related deaths. The report by the Ontario Coroner's Office on methadone-related deaths reviewed toxicology that showed 30% had alcohol and 60% had benzodiazepines in their urines

#### **Hepatitis C**

There are very high rates of hepatitis C and chronic liver disease among long-term injectors and long-term attendees at maintenance clinics. There is reasonable data to indicate that life span is shortened through heavy alcohol consumption in those with chronic liver disease and we can expect to see high rates of End Stage Liver Disease in the coming decade.

#### What do we know?

The risk of interaction occurring appears to be linked to the amount of alcohol ingested i.e. higher levels in the body carry an increased risk of harmful or fatal interaction. Steady state levels of methadone may be altered with chronic liver disease and the use and abuse of other drugs including alcohol. The combined acute effects of alcohol and other CNS depressants can result

in harmful interactions, especially in chronic drug users. Also as methadone has a long duration of action and elimination half-life, when it is ingested with alcohol there is potential for harmful interactions for a period of time after methadone has been consumed. Alcohol interactions may go unnoticed in some cases but are more likely to occur in polydrug users, chronic drug users and older adults.

#### What we know from NTORS?

NTORS was a prospective outcome study of more than 1000 clients who had started a treatment episode in existing clinics in 1995. It looked at in-patient, residential, out-patient services, community based maintenance programmes and outpatient reduction programmes. Excessive drinking was noted among clients in all the treatment modalities. At one year they found that among clients in the community programme there was no overall improvement in drinking and daily heavy drinking still continued at follow-up. After five years they found that many clients made little change in their drinking behaviour and that alcohol consumption among methadone maintenance clients in particular was largely unchanged, if not worsened. Many drug users were drinking heavily, both at intake and at follow-up and they suggested that services should be developed and strengthened to tackle drinking problems among drug users.

NTORS 2001 reported that when drug users come into treatment:

- 68% reported drinking alcohol in the 3 months prior to drug treatment
- 32% had not consumed any alcohol during this period
- 33% of clients drank above recommended limits (and at follow-up were still doing so)
- 14% of the clients drank on a daily basis
- 8% were drinking in the region of 45 units on a daily basis
- Among the drinkers:
  - For men the average alcohol consumption was 50 units per week (compared to 15.4 units in the general population)
  - For women the average alcohol consumption was 45 units per week (compared to 5.4 units in the general population)

#### **After drug treatment**

It is known that some people who have become drug-free develop other addictions, including alcohol. Drug users who are also dependent on alcohol are at greatest risk. But we also know that only 1 in 18 dependant alcohol users are accessing the treatment they require and many people die from alcohol-related causes after exiting alcohol treatment.

WHY is alcohol dependence under-diagnosed?

To quote Malla et al 1987:

'....unlike other disorders (alcohol misuse), is a disease many primary care physicians do not want to detect.

In addition most alcoholics do not want their disease detected'

#### What can we do in primary care?

- 1. Assessment: We need to undertake a full alcohol assessment in all situations where we are seeing drug users. We need to clearly explain the risks in polydrug dependence (as well as remembering to ask about alcohol in all patients in general practice)
- 2. Elicit a good history of their alcohol intake
- 3. Calculate units accurately using:

Volume in ml x strength in % alcohol by volume (abv) divided by 1000 = units of alcohol

4. Drink diary – provide a diary so people can record accurately what they drank and when

#### Management

Management is a balance between safety and keeping people in treatment. Most overdoses occur out of treatment, as alcohol can often be a factor in dropout or discharge from treatment. We need some flexibility in managing the risk and a focus on reducing harm and keeping alcohol change on the agenda.

#### **Alcohol interventions for drug users**

Provide alcohol education and intervention. There are no national guidelines for safe levels of alcohol consumption when dispensing opiates and benzodiazepines and many services use of the Alcometer is different as they use different levels of acceptable breathalyser scores for dispensing medication.

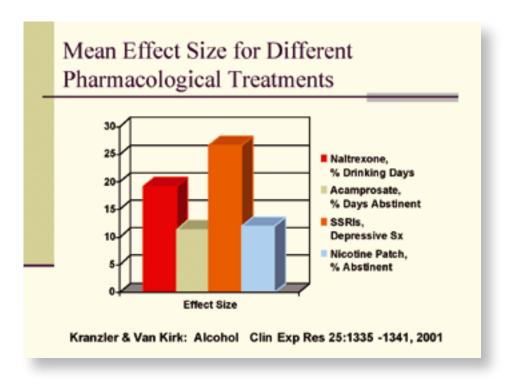
Gossop et al looked at the effectiveness of alcohol and drug counselling and gathered data at intake interviews and at 6 months. He found that the alcohol focused counselling was reported to have been provided to those with higher levels of drinking during admission to the study, but was not significantly associated with drinking outcome at six months. However the authors reported that only a minority of the sample received alcohol focused counselling and that may have been of insufficient intensity or quality<sup>7</sup>.

One randomised control trial (RCT) used a designed Motivational Interviewing (MI) intervention for injecting drug users attending a needle exchange programme. It was delivered in two sessions and found that at six months those receiving MI were over twice as likely as controls to report reductions of seven days or more in their drinking<sup>8</sup>. This study suggests that clinicians can help drug injectors who drink too much and this can be incorporated into treatment.

There is some evidence that psychological interventions such as CBT and MI work (but staff need training in order to deliver these interventions) and support groups such as AA and NA are also helpful. It is also important not to forget psychosocial support for housing issues, finances and to monitor general health.

#### **Does medication help?**

Available medication includes disulfiram (Antabuse) which is helpful in some cases. Naltrexone is showing some encouraging results (see graph overleaf) and acamprosate increased abstinence rates by about 50% in 14 trials. Work is now been done using acamprosate with naltrexone, and topiramate is currently showing promising results in the US.



#### **Choice of substitute medication**

There are no studies to date to indicate preferential outcomes with either methadone or buprenorphine in the combined management of opioid and alcohol dependence. If opioid dependence is recognised with no prior history of treatment it might be helpful to consider buprenorphine because of the reduced but not absent risk in overdose. However there may be a problem with achieving adequacy of dosage.

#### **Maintenance doses of substitute medication**

It is sometimes difficult to get up to a reasonable dose range when there is the associated use of benzodiazepines and alcohol. Patients may actually require a higher dose due to cross-tolerance, but such higher doses are also associated with toxicity. Tricyclics need to be totally avoided because of a very high risk of additive toxicity.

#### **Detoxification from alcohol**

Detoxification can be of benefit but relapse rates are very high. There may be a role for in-patient detoxification and we need to consider providing maintenance drug therapy in a therapeutic community or residential setting where there is strong support after alcohol detoxification.

#### **Conclusion**

Combined alcohol and opioid dependence is associated with higher levels of other drug consumption and is associated with higher rates of mortality and with poorer outcomes including sexual risk taking, suicidality, overdose risks, the exacerbation of HCV and increased risk post drug treatment.

We aren't currently doing very well working with the combined use of alcohol and opioids, and little research has been conducted on specific alcohol interventions for this complex group of people. Further study is required to determine new effective strategies.

But don't forget to ask, review and offer interventions to all drug users using alcohol.

#### **Dr Chris Ford**

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# Substance Misuse and Pregnancyan appraisal of local maternity service guidelines

Melissa Whitworth summarises the findings of her appraisal of local maternity service guidelines for substance misuse during pregnancy. She highlights the significant negative effects of substance misuse on maternal fetal and neonatal health, and finds that local guidelines, where they exist, could be better. She calls for an improvement in communication between secondary and primary care due to the key role that GPs can play in the management of this patient group. She also discusses the importance of multi-agency working, the role of the drug liaison midwife, and patient involvement in the management of their care. She argues that for improvements to be made, national guidance on maternity services and substance misuse should be developed. Ed.

Substance misuse during pregnancy can have significant negative effects on maternal, fetal and neonatal health. However, pregnancy can act as a stimulus for change. Between 2002-2004, 31 women whose deaths were reported to the Confidential Enquiry into Maternal Deaths in the UK (CEMD) were known to have problems with substance misuse (8% of maternal deaths in this period). Such deaths have risen over the last decade. The latest CEMD recommended that women with a substance misuse problem should receive especially close supervision during pregnancy and be managed using evidence-based guidelines by maternity services that are part of a wider multiagency/multi-disciplinary network. Previous studies of medical guidelines have shown that the quality of the guidelines and how they are implemented is often poor. We used the Cluzeau validated quality appraisal instrument1 to look at local guidelines in use in this area to see if they were fit for purpose.

Of the 213 obstetric units in England and Wales contacted by post, 83 units (39%) responded, and of these 29 stated that they had no guideline. Giving a sample of 54 local guidelines for assessment. The Cluzeau instrument consists of 37 items divided into three dimensions: rigour of development (e.g. strength of evidence base), context and content (e.g. target groups, clinical context) and applicability (e.g. dissemination and implementation strategies). For each item possible responses are 'yes' (value 1), 'no', 'not sure' or 'not applicable' (all value 0). Results are standardised as a percentage of the maximum possible score for the dimension. It is possible to achieve a quality score ranging between 0 and 100%. A series of good practice points were also assessed.

#### **Findings**

This study provides a unique insight into the quality of guidelines used in the management of pregnant women with a substance misuse problem. The Cluzeau instrument quality scores were: rigour of development, 15% (range 0–55%); context and content, 33.3% (range 8.3-58.3%) and application 5.9% (range 0-40.0%). Whilst the context and content dimension achieved significantly higher quality scores (p<0.001 versus rigour of development and applicability) scores were poor in all dimensions. No guideline contained all 12 harm minimisation good practice points.

The majority of guidelines (77.8%) recommended management in a multidisciplinary care setting as per the CEMD. GPs play a key role in the management of many patients with a substance misuse problem and are likely to be the first medical port of call for the pregnant woman with a substance misuse problem. It is therefore depressing that only 11% of guidelines included the GP as part of the multi-disciplinary team. In addition only half (51.7%) recommended informing the GP if the patient was admitted to hospital during pregnancy. This may be a reflection of the hospital/ primary care divide, whereby GPs often seem to be regarded by secondary care as unequal partners in patient management, suggesting a lack acknowledgement of their specialist skills.

The latest CEMD recommended that as part of multi-disciplinary care all pregnant women with substance use problems should receive the support of a known midwife throughout pregnancy. Of the guidelines appraised, 58.5% recommended referral to a 'drug liaison midwife' (DLM) suggesting that service provision is developing in this area. One

study<sup>2</sup> reported retrospectively on the first year of operation of a specialist DLM service created to liaise between hospital and drug treatment services. Their descriptive findings suggest benefits associated with this service model with all but one woman retained in drug treatment throughout the course of pregnancy. Hopefully the service provided by DLMs will be the subject of prospective evaluation as at present there is no research evidence as to precisely what model of antenatal care DLMs should offer, with a Cochrane systematic review, concluding 'there is insufficient evidence to recommend the routine use of home visits for women with a drug or alcohol problem'. A potential difficulty with this approach is that concentrating specialist knowledge into a lone midwifery practitioner within an obstetric service may result in the 'collapse' of the service during periods of leave.

It is recognised that in order to promote inclusion and empowerment it is essential that the patient is involved at all stages of drug treatment planning. Appraisal questions in the Cluzeau instrument acknowledge the role of 'user' participation, for example:

'Is there an explicit statement of how the patient's preferences should be taken into account in applying the guidelines?'

For such questions positive scores were obtained in 7-25 (13-46%) of guidelines reflecting poorly on the ability of guidelines to involve the patient in the clinical management process.

#### **Conclusion**

Overall the standard of guidelines assessed in our study was poor. Guidelines did not take a clear a harm minimisation approach and were not designed to facilitate or encourage multi-disciplinary working. In addition they failed to involve the patient in management decisions. Perhaps the time has come for a truly multi-disciplinary panel to develop a national guideline which can be adapted to local needs.

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# Child care legislation-implications for practice

This article provides a guide to the Children Act 2004, due to be implemented by the end of 2008. The Act aims to involve all health and social care agencies in the provision of early assessment and intervention for children in need, and emphasises the importance of preventative work with children and their families.

Hidden Harm¹ established a clear link between parental problem drug use and harm to children. Whilst it is important to make the point that many parents who use drugs are good parents, as practitioners we need to bear in mind that problematic parental drug use can increase the risk of harm to children. This article will give a brief overview of child care legislation in the UK and how recent changes to the law are likely to effect practice in health and social care.

#### The Children Act 1989

The Children Act 1989 is the underpinning legislation relating to child care law in England, Wales and Northern Ireland (in Scotland the Children (Scotland) Act 1995). This Act places responsibility on Local Authorities to safeguard and promote the welfare of children. It also legislates for the cooperation of health authorities regarding children in need and at risk. There are two sections of the Act, section 17 and section 47 that are commonly used when there are concerns about a child's well-being.

#### Section 17 Children in Need

A child is defined as being in need if they are "unlikely to achieve or maintain or have the opportunity of achieving or maintaining a reasonable standard of health and development without provision for them of services by a local authority".

The aim of this section is to *prevent harm* to children, rather than to intervene because of risk. This section of the Act advocates supportive interventions and requires the consent of families to be involved with social services: it is therefore *voluntary*.

#### **Section 47 Significant Harm**

The act defines significant harm as 'ill

treatment or impairment of health or development

Ill treatment includes sexual and emotional as well as physical abuse'

This section carries more legal weight, *and does not require the consent of families* for local authorities to intervene. The legislative power of this section includes the power to accommodate a child in local authority care.

#### **Children Act 2004**

Health care professionals have traditionally referred to social services when children are believed to be in need or at risk of significant harm. Many social services departments have however struggled to deliver services to children in need, as referrals for children at risk of significant harm will always be the first priority.

The Children Act 2004 (which covers England, Wales, Scotland and Northern Ireland) does not replace the 1989 Act but strengthens it, and places an increased responsibility on agencies other than social services, including health services, to become more involved in the assessment and intervention stages to prevent harm to children in need. The Act also requires the earlier sharing of information, and multi agency working.

#### **Key areas**

#### The Common Assessment Framework (CAF)

The CAF is an 8 page common assessment tool that can be carried out by anyone working with the children and their family including health visitors, midwives, youth workers, family workers, and substance misuse workers. The CAF will form the core of interagency referrals from universal frontline staff.

A CAF should be used when a child's needs are not fully understood and/ or are not being fully met, but not if the child may be at risk of harm, in which case they should be referred directly to social services.

#### **The Lead Professional**

If the CAF suggests that a child requires a multi-agency support plan, then a Lead Professional should be designated. A lead professional can be anyone working with the children and their family, however pilot schemes have suggested that health visitors and school nurses have most commonly taken on the lead professional role. The Lead Professional's role is to:

provide a single point of contact

- ensure that children and families get appropriate interventions when needed, which are well planned, regularly reviewed and effectively delivered
- reduce overlap and inconsistency from other practitioners

#### Children's support meetings (often known as Team Around the Child (TAC) meetings)

Children's Support Meetings are a tool for workers in all agencies or organisations. A meeting can be called by anyone working with the family, with the aim of meeting the needs of the child through coordinating a multi-agency response.

#### **ContactPoint**

ContactPoint will be made available to all local authorities in England during 2008 and is a basic online directory, available to authorised staff who need it to do their jobs. Information held will include

- Basic identifying information for all children in England (aged up to 18): name, address, gender, date of birth and a unique identifying number.
- Basic identifying information about the child's parent or carer.
- Contact details for services involved with the child: as a minimum, educational setting and GP practice, but also other services where appropriate.
- A means to indicate whether a practitioner is a lead professional and if they have undertaken an assessment under the Common Assessment Framework

#### **Conclusion**

It is the responsibility of local authorities to impliment the Act locally by 2008, so guidance and training is likely to happen over the next 12 months if it has not done so already. The changes are likely to encourage prevention of harm to children at an earlier stage, however it will clearly impact on the workloads and responsibilities of health and social care practitioners.

#### Kate Halliday SMMGP Associate

#### References

1 The Advisory Council on the Misuse of Drugs (ACMD) Hidden Harm: Responding to the needs of the children of problem drug users 2003

All reports relating to the Children Act 2004 can be found on DoH website www.dh.gov.uk



#### Dear Dr Fixit

Can I ask your advice about Mark who is 28 years old and has been a patient of mine for 4 years? He has been very stable on methadone maintenance of 120mg of methadone mixture for over 18 months and only occasionally uses cocaine and diazepam and very rarely heroin. He does not drink but smokes at least 20 cigarettes a day.

He is currently well and is working as a volunteer. He is in a stable relationship with a woman who does not use drugs and they would like to start a family but Mark really wants to be drug-free before this. He has tried a community detoxification several times over the years but has never completed. He feels that he needs to do an in-patient detox programme, followed by rehabilitation, perhaps as a day programme and I agree.

But here is the problem. In our area you have to reduce to 30mg before you can be offered in-patient detoxification. We both feel that this is inappropriate in Mark's case. There is no doubt about his commitment and he already has funding in place to go on to rehab (either day or in-patient) but he feels it is impossible to get to 30mg in the community without relapsing.

What do you think of our local policy and can you suggest how we can proceed? Thank you

At first glance, the policy of restricting admission to people who have reduced to 30mg/day seems unjustifiable. Studies on severity of acute withdrawal indicate that withdrawal severity is the same in people withdrawing from doses across the dose range 30-100mg. Asking Mark to reduce to 30mg in the community, something he has found impossible, thus appears to be thwarting his laudable aspiration to go drug free.

However, the evidence relating to treatment outcomes provides a sharp reality check. Most people coming off methadone don't manage to stay abstinent in the long term. The patients with the best prospects are those who have abstained from heroin and other injected drugs for many years, and who have a job and a stable relationship. Mark does not meet these criteria. Even if he did, statistics suggest that he would still only have a 50% chance of remaining abstinent from opioids long term.

Some people withdrawing from methadone do achieve stable abstinence, and that sustains the faith of most people in the community, of most drug users, and of many professionals working in drug treatment, that there is no harm, and potentially lots of benefit, in people trying to go drug free. Sadly, again evidence provides a reality check, for there are several harms associated with attempting a treatment which in most cases will fail. Quite apart from the waste of scarce health resources, studies from the UK and Europe have documented a significantly increased death rate among cohorts of opioid-dependent people attempting detoxification. The increased risk of death is due to overdose when people relapse. The price of failing can be very high indeed.

There are other serious risks. Many adolescents avoid the maturational challenges of individuation by using drugs, asserting a spurious independence by breaking rules. Once drug dependent, too many of these individuals then spend their early adulthood continuing to avoid the challenges of responsibility - job, relationship, family - by insisting that they'll do those things once they are off drugs. So they get in treatment, settle down – then withdraw from treatment, and relapse, and the cycle starts again. It's a self-defeating cycle, and a tragic loss of human potential. By supporting people in this cycle, we reinforce avoidance and compromise their long-term recovery.

Inpatient treatment is usually seen as a time for major change. In fact, sustainable change is mostly gradual and incremental, something that happens almost imperceptibly over time, and cannot really be hurried. Rapid change is unstable – a person who renounces drugs today can also relapse tomorrow. The best "treatment" of drug problems is involvement in life – which for most of us means relationship, family, and job. Those are long-term, sustained challenges. The benefit of methadone treatment is that it allows drug users the opportunity for social reintegration, for building a life – something difficult to do while using heroin compulsively. Putting off life challenges until after you have come of methadone is like taking off your parachute before jumping from the aeroplane.

Research in neurosciences helps clarify why relapse is so common. Long after acute withdrawal symptoms have settled, people who have been drug dependent experience persisting dysphoria and craving, with elevated stress

responses and anxiety. These responses occur after stopping most drugs, including stopping smoking. What neuroscientists are reporting is little more than what AA recognised more than half a century ago. The risk of relapse

is lifelong, which is why AA recommends lifelong affiliation to

the fellowship to preserve sobriety and deal with relapse.

For these reasons, the best advice for people on methadone, if they want to reduce—and nobody can stand in the way of a valid request to do so—is to withdraw, very slowly, in the community—as recommended in NICE guidelines. If your patient finds himself using heroin again, or taking benzodiazepines, put the dose back up until they are stable before thinking of reducing further.

There is little place for in-patient withdrawal from methadone, and such treatment does not improve the likelihood of sustained abstinence. Patients and families often believe

that the only thing standing between them and recovery is an obstructive admission policy. They are displacing frustration at the intractable and defeating nature of addiction onto services. As doctors, we need to remain supportive, but also need to avoid displacement and magical thinking. We serve our clients best, not by supporting them in whatever they want to do, and certainly not by taking "their side" against local services, but by our competence and professionalism. In methadone treatment that involves accurate information, adequate dose, and close clinical monitoring. It involves gently steering people around their own longstanding but dysfunctional defences, such as avoidance. It also involves helping patients deal with the shame and family pressure which is so often pushing them towards leaving treatment.

# Answer by James Bell Consultant in Addictions at SLAM (South London and Maudsley NHS Foundation Trust)



#### Dear Dr Fixit

Carl aged 17 years came to see me. I knew he was going to come as his mother had been to see me the week before, saying she was worried about him as he was smoking a lot of cannabis and she was anxious because she had heard about skunk and he was not doing as well as previously in his studies. Carl has been registered since birth and the family are well known to the practice.

Carl started by saying he was only there cause his mother had insisted, but he soon began to talk about how his skunk use had increased from once or twice a week at the weekend to every evening and now during the day as well. He had tried to stop several times but had found he always became increasingly anxious and didn't sleep. He takes no other drugs, confirmed on urine testing, only very occasional alcohol, and has no other problems.

He asked me if I could help him cut down or suggest places he could go to get help. I gave him some basic harm reduction advice but I haven't really managed a young man with cannabis problems. Can you help me?

Carl's presentation provides an opportunity to do several things which may help him initiate positive behaviour change. You can support and enhance his motivation, assess the nature and extent of his cannabis use or possible dependency and also provide him with clear information about the risks of cannabis use and in particular skunk.

His high frequency of use combined with the strength of the cannabis that he smokes increases the chance of negative consequences. The assessment information you have gathered suggests that he has developed tolerance and is experiencing withdrawal symptoms. Although the contribution of physical dependence to chronic cannabis use is not yet fully understood and the above symptoms in themselves are neither necessary nor sufficient for diagnosis

they are clearly obstacles to behaviour change and suggest the need for targeted interventions <sup>1</sup>.

Why does he want to change? Listen to Carl carefully and reflect back his concerns. What does his mother think about the situation? She has been able to get him to attend your appointment, might she be prepared to support him and how would he feel about her being involved so she can understand his difficulties and the help he will need to make this change? Does he want to cut down or stop completely?

Preparing him with knowledge of likely withdrawal effects will help him to understand what is happening and prepare for the adverse symptoms. These may include irritability, restlessness, anger, aggression, sleep difficulty, decreased appetite and weight loss<sup>2</sup>. Re-assure him that these will pass in 2 to 4 weeks. Any activities that absorb or relax him will be beneficial at this time. The '4 Ds' can be a helpful reminder of what to do when he is craving. Delay: delay for at least 5 minutes, the urge will pass. Drink water: take time out, sip slowly. Deep breathe: slow full and deep breaths and finally Do something else: keep your hands busy.

Further assessment of the psychosocial factors influencing his cannabis use will provide information to indicate whether he is likely to be able to make changes without more intensive support. Variables such as peer pressure, low self-esteem and deficient life skills may be contributing factors which make him vulnerable to relapse<sup>1</sup>. This information may be obtained by attempting to elicit the impact of his cannabis use on his social and school life. Perceived negative effects may influence his motivation to change whilst any positives of cannabis use will likely point to reinforcing and potential relapse factors.

Identifying these factors may be enough to help him to begin to address them, especially if he has family support. You can direct him to online resources such as 'www.knowcannabis. org' which provides an online support programme. If it becomes clear that Carl will need more intensive support then you can offer to refer him to a local young persons service which offers support around drug use (providing of course there is one available in your area; the FRANK help line should be able to advise on this).

Giving Carl some clear information about the risks and negative effects of his cannabis use may help to promote behaviour change. However scaring him is likely to prove counter productive. Your assessment suggests his self-efficacy judgements (his own beliefs about his ability to change his smoking behaviour) are likely to be low (he has thus far been unable to make a change) and research has shown that creating fear in this case is likely to leave him with a sense of futility and may serve to further entrench the behaviour he wants to change<sup>3</sup>. You should emphasise that

it is normal to have setbacks when making changes.

Cannabis is a psychoactive drug and can undoubtedly cause paranoia and exacerbate mental health problems. There is sufficient evidence to warn young people that cannabis use could increase their chances of developing a psychotic illness in the future<sup>4</sup>. However the picture of how this may happen is still not clear and there may be other negative effects which are more relevant to Carl. These include the negative effects which continuing to smoke may have on his self perceptions, for example, feeling bad about using, lowered self-esteem and reduced self-confidence as well as perceived impacts on energy level and procrastination and concerns about memory loss<sup>1</sup>.

Positive emotions increase thoughts about personal success and it is important to communicate both implicitly and explicitly that change is possible. Explaining, for example, that while concerns around memory loss are common research has not demonstrated that there is any major cognitive dysfunction associated with cannabis use except perhaps in some heavy users, and some findings suggest a return of full cognitive function within a month of abstinence<sup>1</sup>. This kind of approach is more likely to instil hope and support positive expectancies about the possibility and desirability of change.

Finally arrange to see him regularly over the next few weeks to get some feedback about how he is doing and any difficulties he is having.

#### Answer by James Oliver Specialist Drugs Counsellor Lonsdale Medical Centre

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